ELTA DE TAL®

Enrollment — Non Voluntary

Group Name

Delta Group/Division Number

Last First Middle Initial

_____-_____-_____ (Member I.D. Number)

_____/_____/_____ Month Day Year

® Change in enrollment ® Rehire ® Delta Vision

Birthdate Month Day Year

_____/_____/_____

Sex
® Male
® Female

Marital Status

Do you have dependent children?
® Yes
® No

Does your spouse have a dental plan? ® Yes ® No

If yes, who is covered: ® yourself ® spouse ® dependent children

If Delta Dental, indicate group number: _____

Employee Classification

® Certificated ® Full-time ® Part-time
® Classified ® Hourly ® Retired
® Salaried ® COBRA

Mailing Address _____ Telephone Number (_____)_____

City _____ State _____ ZIP code _____

® COBRA Enrollment

I understand that I may be required by the employer to pay for COBRA benefits

B Change to Existing Enrollment (Complete all sections that apply)

® Name change ® Add new dependent ® Delete dependent ® Address change listed above

Reason for change _____ Effective date of change _____/_____/_____ Month Day Year

C DEPENDENTS (Complete for new enrollment or to add or delete dependents)

Spouse Name Last (if different) / First / Middle Initial	Add/ Delete	Sex M F	Birthdate Month Day Year	Marriage/Divorce Date Month Day Year	Spouse's Social Security Number
			_____/_____/_____	_____/_____/_____	

Child Name Last (if different) / First / Middle Initial	Add/ Delete	Sex M F	Birthdate Month Day Year	If Child is 19 years or older (check one) Full-time Student	Disabled	Child's Social Security Number

D Signature (Form must be signed to be processed)

(Forwiy YI e tem musts ofYI e grame Socia8(ont eeeture)Tj E_____MC <<

6

6